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SCHOOL PHOBIA--A SYSTEMS APPROACH.

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THE SCHOOL PHOBIA SYNDROME PROVIDES AN EXAMPLE OF THE SCIENTIFIC DEVELOPMENT OF A CLINICAL SYNDROME. A REVIEW OF RELEVANT LITERATURE REVEALS THAT DETERMINANTS OF THIS PHOBIA ARE INTRAPSYCHIC, INTERPERSONAL, FAMILIAL, AND COMMUNITY FACTORS. WITH SO MANY FACTORS INVOLVED, AN EXTENSION OF THE CURRENT APPROACH TO THE PROBLEM WOULD INVOLVE FAR TOO MANY DISCIPLINES. A SYSTEMS APPROACH FOR EXAMINING SCHOOL PHOBIA IS THEREFORE SUGGESTED. SUCH AN APPROACH IS PROBLEM-CENTERED RATHER THAN DISCIPLINE-CENTERED. IT VIEWS THE TOTAL FORCE FIELD RESULTING IN A PARTICULAR SYNDROME, AS WELL AS THE INTERFACES WHERE DIFFERENT FORCES INFLUENCE ONE ANOTHER. INFLUENCING THE VARIABLE ARE NINE FORCES WHICH PROGRESS FROM THE ORGANISMIC LEVEL TO THE NATIONAL LEVEL. WITHIN ANY ONE LEVEL, THERE ARE SEVERAL DIMENSIONS. THE SYSTEMS APPROACH STUDY OF THE SCHOOL PHOBIA ALSO FOCUSES ON THE END RESULT OF SCHOOLING. THUS, SCHOOL PHOBIA CAN BE VIEWED AS A SUB-CLASS OF GENERAL LEARNING DISORDERS. WITH THE QUALITY OF LEARNING AS A DESIRED END PRODUCT, A VARIETY OF STRATEGIES IS AVAILABLE. INTERDISCIPLINARY APPROACHES CAN BE USED IN SOLVING THE PROBLEM, BUT AT NO TIME SHOULD ONE LOSE SIGHT OF THE INDIVIDUAL CHILD. THIS PAPER WAS PRESENTED AT THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION CONVENTION, (44TH ANNUAL MEETING), WASHINGTON, D.C., MARCH 22, 1967. (SK)

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SCHOOL PHOBIA: A SYSTEMS APPROACH

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INTRODUCTION

The syndrome of school phobia or school refusal furnishes an exceptionally clear example of the development of knowledge about an emotional disorder. Because of its short history which coincides with a period of rapid scientific growth, the syndrome provides an opportunity for the tracing of its development from first recognition through progressively complex differentiation to the present need for a useful, integrative theory. This paper, therefore, has two aims; first, to trace the developmental history in order to demonstrate the need for new theory, and second, to outline the contribution of general systems behavioral theory to the understanding of the syndrome.

HISTORY

It is possible to distinguish five steps:

I. The first was for the condition to become labeled as a disorder. This occurred when school attendance was made mandatory. In the United States, school attendance became gradually required during the 1800's, but attendance through 16 was not required until 1920 in some states. Hence, concern over school avoidance is not only of recent origin, but the distinction between truancy and illness explanation[3] of school avoidance continues to be quite variable according to local attitudes.

II. Next was the differentiation of types of school avoidance from within the total group of children. Just 35 years ago, Broadwin (5) described a "form of truancy which.....occurs in a child who is suffering from a deep seated neurosis..."

His six cases avoided going to school because of severe anxiety and obsessional ideas that some harm would befall the mother. Nine years later, Johnson and co-workers (13) described factors common to eight cases they had studied and introduced the term "school phobia", emphasizing that separation anxiety was the major element. Several years later, Klein (16) expanded this finding and reported that whether truancy was acute or chronic, there were three common elements; anxiety, aggression and secondary gain. However, other than this paper, the similarities between school phobia and other types of school refusal and truancy received much less attention than did the differences for the next 10-15 years.

III. The third step in the development of clinical knowledge was the occurrence of increasing complexity as new aspects and connections were identified. It became recognized that some of these children had characterological or even psychotic disorders (7, 21) and several reports called attention to the importance of depression in school phobic children and parents (2, 10). The existence of severe bi-sexual conflicts was identified (1) and a study of the patterns of aggression revealed the existence of profound oral sadistic conflicts originating in the early mother-child relationship (8). These and other studies gradually led to the recognition that in many if not most cases, school phobia was but one manifestation of a family disorder (18), and the term school refusal was suggested (14).

In addition to the clarification of these intrapsychic, interpersonal and familial determinants, the experiences of Waldfogel, Coolidge, and Hahn (28)

working directly with teachers and principals within the school itself, added a new dimension. This was the contribution of the school as a social system to the identification of children with school phobia. These investigators found that direct consultation within the school led to a tenfold increase in recognized cases within a three-month period. They comment, "It would seem then that many cases of school phobia persist undetected by ordinary referral methods and untreated over long periods. The bulk of these seem to be chronically crippled children operating with marginal adjustments, who need to be reached more urgently than those youngsters whose disturbances are more dramatic." Strong support for this finding was recently reported from a longitudinal study of child development by Moore and co-workers (25). They found that some degree of reluctance to attend school was present in 60-70% of their six, seven and eight-year-olds, and about 1 in 5 developed a serious aversion to school.

IV. Recognition that the classical form of school phobia was simply the tip of an iceberg of unmet need, led to the fourth step in the development of our knowledge, namely attention to the school environment and other social influences. This step has been characterized by the emergence of public health and prevention oriented approaches. Attention to environmental and social forces led to new discoveries in both education and mental health which have a high degree of congruence. In education, it was recognized that segregated schools, small rural schools, and large slum schools presented a massive threat to educational good health. Corrective measures included efforts to alter patterns of segregation, to encourage consolidation of rural school districts, and to provide cultural

enrichment programs for slum children. Keppel's (15) description of the "fortress school" in the slums, surrounded by a high fence and closed evenings and weekends against a feared environment reminded us that a school can be phobic. Just as the phobic child is symptomatic of a family disorder, so the school is a manifestation of a broader community disorder. In both, one sees breakdown in patterns of communication and the emergence of primitive forms of sex and aggression.

Interest in social and environmental forces on the part of mental health professionals resulted in finding a large group of children who could be termed "pre-school phobic". I am referring to children in severely deprived families in big city slums. These children show a striking and pathological lack of anxiety upon leaving mother and starting nursery school. Pavenstedt and co-workers (26,19) found that separation represented such a threat that it had to be massively denied, a defense which led to severe constriction and inability to learn in the school environment. In fact, only after the children had attended nursery school for some months and felt much more secure in that setting, were they able to show any separation anxiety. In short, these children are so massively phobic that they are incapable of showing the type of acute anxious school refusal seen in children who come from more advantaged families. Instead, it suggests that the classical school phobic reaction occurs in children whose separation disorder occurs within a setting of adequate socio-environmental support where the disorder lies mainly in familial, interpersonal, and intrapsychic areas. On the other hand, the group of pre-school phobics are children who have, in addition to this, the disordering effects of a phobic school and a disorganized community.

V. The recognition that school refusal is a complex syndrome involving a range of factors from intrapsychic to community levels requires a theory able to accomodate this range. This is the stage in clinical scientific development that we are currently at. It is highly unlikely than an extension of current inter-disciplinary approaches will help, as there are simply too many disciplines involved. An alternate approach that has attracted considerable interest in many fields, including our own, is the adoption of a "systems approach".

A SYSTEMS APPROACH TO SCHOOL PHOBIA

By a systems approach I mean a point of view or a way of looking at behavior. The underlying theory has been presented as general systems behavior theory by James G. Miller (22, 23, 24), and Young recently published an overview of the theoretical concepts (27). Auerswald has discussed differences between interdisciplinary and systems approaches (3), Carroll and co-workers (6, 17) its application to psychoanalysis, and Frederick Duhl the therapeutic implications (11).

The first important characteristic of a systems approach is its <u>problem centered</u>, versus discipline centered, orientation. It attempts to view the total field of forces that result in a particular problem or syndrome and the interfaces where different levels mutually influence each other. From my review of school phobia, these forces include the child, family, school, community, region, and education as a social institution. In a given case, the relative

contributions of these factors may differ widely, but the same end result, school refusal, may be arrived at through many combinations. Bertalanffy has called this "equifinality", to indicate that the same result may occur from different initial conditions (4). The following nine levels are suggested as being useful for viewing the range of variable involved.

1. Organismic
2. Intrapsychic
3. Interpersonal
4. Family
5. Organizational
6. Institutional
7. Community
8. Regional
9. National

Some of these levels represent systems in themselves, for example the individual, the group, and the organization and some represent interactions between systems, for example interpersonal and institutional.

Because the mental health professions have largely worked with the first four levels, these do not need elaboration here. It is worth noting, though, that one reason for the importance of the family as a level for therapeutic intervention is because it serves major adaptive and/or defensive functions between the individual and the community.

The organizational level refers to the range of forces operative within the individual school as a formal organization. This small social system has the task of the transmission of knowledge, and towards this goal the school has a series of differentiated functions among administrators, teachers and needed specialists such as a nurse, psychologist or social worker. Not only are there formal role relationships and communicative links, but also a variety of personally-defined roles and informal patterns of communication. In short, it has both the assets and liabilities of a small bureaucracy (20). The report of a ten-fold increase in recognized cases of school phobia when working directly with principals and teachers indicates clearly that in the identification of cases, the organizational level is by far the most important.

The institutional level refers to the range of forces that involve education as a major social institution. Although this level might appear to be far removed from the final common pathway of the ego and the individual child, there are a number of ways by which institutionalized patterns affect school attendance. Most obvious are those that arise from the regularization of the educational process that accompanies the establishment of standards. The use of chronological age in determining eligibility for school results in the admission to school of immature children who meet the age requirement but excludes more mature children born a few days too late. Likewise, boys and girls are generally treated the same in school, despite major developmental differences between them. The need to sit still for long periods of time and be taught, almost invariably, by women creates a school environment that favors girls and passive boys. It has

been suggested that this institutional factor is responsible for the much higher incidence of learning and behavior disorder among boys than girls in the latency age range. Other examples of institutionalized practices that have received much critical note are the widespread use of texts featuring Dick and Jane as white, Anglo-Saxon protestants living in the green suburbs.

The community can be regarded as including all the preceeding levels as they interact within a given geographic area and are influenced by local tradition and economic, cultural, and ethnic forces. The enormous impact of community factors on school attendance can be seen simply by comparing schools in the central city with those in the suburbs (9). Not only does one encounter phobic schools, but also finds that segregated schooling, de facto or otherwise, can be seen as a type of "school refusal" whose prevalence in some areas is of epidemic proportion and far exceeds the number of individuals avoiding school because of anxiety. Some feel it is entirely within the role of the mental health professional to devote as much time to institutionalized causes of school refusal as he does to individual cases of school refusal.

The final levels are those of the region and the nation. The impact of regional forces is best seen in the current trend in rural areas to join together to develop combined schools. In many cases, these result in educational systems of a very high caliber, both in instructional and in counseling areas. The relevance of national frces has become increasingly clear in recent years due to the impact of congressional laws on education segregation, and by way of aid to schools.

A second characteristic that follows from the problem-centered orientation of a systems approach is its focus on the product or end result that is defined as being the problem. We noted that school phobic children were differentiated as a sub-class of children who were truant from school. The basis for the differentiation was the presence of visible anxiety, despite Klein's early recognition of the basic similarities between phobic and truant children. Thus, the problem was defined as anxiety, instead of failure to attend school. This defect was noted by many, especially Eisenberg (12), who stressed the need for early return to school as an important part of treatment. However, the desired end result is not simply school attendance, for many children can attend marginally and yet be psychologically absent from school. Rather, the desired goal of school attendance is for children to avail themselves of what school has to offer, namely, learning and socialization. In short, school phobia may be seen as a sub-class of the broad group of learning disorders. The <u>quality of learning</u> then becomes the end result, and the choice of strategies for influencing the end result depends upon the assessment of the most strategic leverage points. This might include drugs, psychotherapy, family counseling, the new math, more school support, community development, social action, legislation and so on. Not only does such a systems approach offer a framework for relating this range from medication to legislation, but also it indicates the areas of contribution of the various disciplines without losing sight of the individual child.

SUMMARY

School phobia, because of its brief history and the rapid advance of knowledge, serves as an exceptionally clear example of the scientific development of a clinical syndrome. A review of the literature shows a steady progression from intrapsychic to interpersonal to familial levels. As these became identified, the view enlarged to the school as a formal organization, education as a social institution, and the community as a unit in which these many forces come together.

Systems theory offers a way of organizing this range of variables and suggests an operational approach. Because the focus of this paper is on the application of a systems approach, the use of systems concepts is selective. Those that are stressed are first, the application of a problem-centered (versus discipline-centered) approach, which looks at the total field of forces and at the interfaces where different levels interact. Probably because of the artifacts of the disciplinary approach, these interfaces now offer particularly effective points for obtaining therapeutic leverage and initiating change. Nine levels of analysis and/or intervention are listed, ranging from the organism to national levels and from drugs to legislation and social action.

Second, a focus on the end result of schooling makes it clear that the common denominator linking the anxious school refusal of a socio-economically advantaged child, and the deceptive absence of anxiety in disadvantaged children to the barriers of a phobic school and the variety of school refusal called segregation, is a disorder in the quality of learning. Analysis of the relative

influence of the different levels to a given case should both foster better interdisciplinary collaboration and maintain the essential wholeness of the individual child.

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